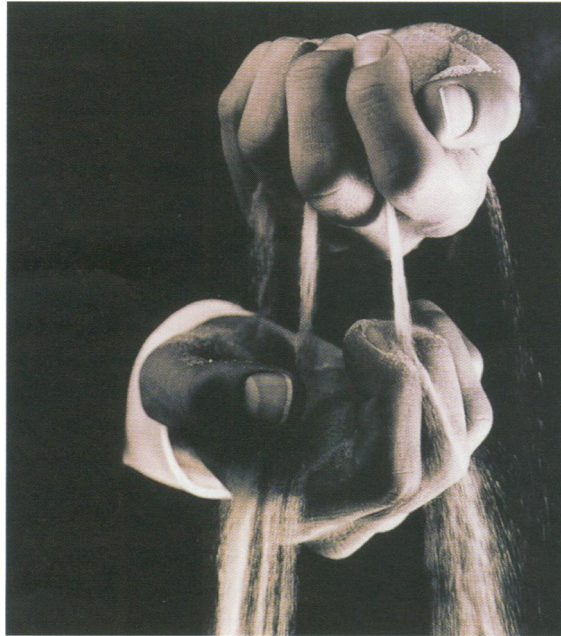


# Culture and Medicine

## Nonbeneficial or futile medical treatment: conflict resolution guidelines for the San Francisco Bay Area

By the Bay Area  
Network of Ethics  
Committees (BANEC)  
Nonbeneficial  
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*Sean Ellis/Tony Stone Images.*

### The need and potential for area-wide guidelines

Most people now die in a health care setting, so that decisions about when to terminate medical treatment are common. Many patients approach death without leaving instructions as to their desires. Surrogate decision-makers such as family members may disagree among themselves and with caregivers as to when "enough is enough." Stalemate situations are increasing, especially where the clinicians feel a patient cannot improve but families insist on invasive medical treatment and/or life support measures. The concept of "medical futility," is as old as Hippocrates. A growing literature has tried to develop clinically useful standards for arriving at a definition of non-beneficial treatment, ethical standards for decision-making, and dispute resolution procedures.

### Methods for gaining consensus

The Bay Area Network of Ethics Committees (BANEC), an informal network of clinicians and others interested in the ethics of healthcare (members at meetings represent approximately thirty healthcare institutions throughout the San Francisco Bay area), began presenting meetings on nonbeneficial care in 1995. A working group of 10 representatives of ethics committees from various Bay Area health care institutions

drafted the following guidelines, which have had input from open review meetings attended by over 100 BANEC participants. The guidelines are now offered for consideration by any institution confronting this topic. When institutions develop such guidelines, they should be put on the public record and disseminated in the community. We would recommend public input whenever such policies are developed.

These guidelines intend to reflect the best standards of the medical profession in making difficult decisions about limits to treatment, especially when it is judged that specific treatments are not, or would not be, in the physicians' professional opinion, in the best interests of the patient. We recognize that legal risk management is likely to be a concern, but it is our conviction that medical concerns are the basic standard for decisionmaking. Use of the institutional ethics committee, with broad representation including community membership, is recommended primarily to increase communication among everyone involved in such cases.

### Conflict resolution guidelines

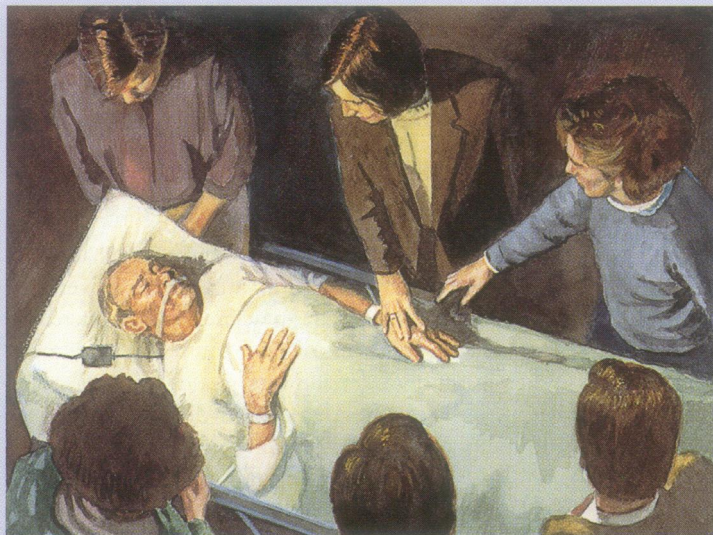
#### 1. Defining nonbeneficial treatment

Nonbeneficial treatment is any treatment that, in the best judgment of medical professionals, produces effects that cannot reasonably be expected to be experienced by the patient as beneficial, or to accomplish the patient's expressed and recognized medical goals; and/or will probably cause harm that outweighs any expected benefits. Potential examples of nonbeneficial treatment that have been raised for discussion include: (a) Provision of life sustaining treatment to a patient who is irreversibly unconscious; (b) Provision of any treatment other than comfort care when a patient has requested only comfort care; (c) Provision of indeterminate, long-term treatment to a patient who has no realistic chance of surviving outside an acute care hospital intensive care unit.

#### 2. Determination of nonbeneficial treatment

The physician responsible for the care of the patient is responsible for making a determination that an intervention is medically nonbeneficial, and therefore inappropriate. When the physician and consultants, supported by the medical literature, conclude that further treatment (except comfort care) cannot, with reasonable probability, benefit the patient, such treatment may be judged to be nonbeneficial. When such a judgment





Family members may all be involved in end-of-life decisions. *Robert Bergin/Stock Illustration Source, 16 West 19th Street, New York, NY 10011; e-mail sis@sistock.com.*

## Case histories

(Cases provided by Lawrence Schneiderman, MD and Steve Heilig, MPH, based upon composites of real cases. Details have been altered to protect confidentiality).

### CASE 1

A 35-year-old homeless diabetic Caucasian man is found unconscious with severe hypoglycemia. Despite maximal life-saving treatments, he remains in a persistent vegetative state. No family or friends can be found. A decision must be made as to whether to keep him on life-sustaining treatment, consisting of tube-feeding and insulin with close monitoring.

This case illustrates both the problematic medical/legal environment in this country and the usefulness of procedural guidelines. The patient's physician obtained a neurological consultation. The neurologist concluded, after 3 months had passed, that the patient was in a permanent vegetative state and had no reasonable chance of regaining consciousness. The patient's physician proposed that, since the hospital had a futility policy that defined life-sustaining treatment of a permanently unconscious patient as futile, that tube feeding and insulin be discontinued. The hospital risk manager insisted that treatment be continued until a guardian could be appointed by local authorities, who could then make a court-supported decision on behalf of the patient. The physician objected that such a process could take months, and argued that the existing care team could represent the patients' interests just as well as an appointed guardian. The physician asked the ethics committee to review the case. The whole committee, made up of hospital and community representatives, supported the physician's position. It proposed that the patient be transferred to a hospital whose policy did not define life-sustaining treatment of a permanently unconscious patient as futile, or to a skilled nursing facility. If no such transfer could be arranged, the physician was entitled to withdraw life-sustaining treatment in accordance with hospital policy.

has been made, a recommendation to withhold or withdraw the intervention should result, and the following should occur, at a minimum:

- A. Patients with medical decision making capacity should be informed of the judgment, the medical rationale supporting it, and the alternatives and their likely outcomes. The physician should explain that withholding or withdrawing the intervention still means appropriate medical and humane care will be provided.
- B. For patients without decisionmaking capacity, the discussion and understanding as described above should be sought from a surrogate decisionmaker. If surrogates cannot be located, the physician, after appropriate consultation, should be able to make decisions regarding discontinuation of treatment. When multiple surrogates are available but in conflict, a single surrogate should be chosen. In all cases, the surrogate should provide evidence that the surrogate's position is in accord with what the patient would desire, or if such desires are unknown, are consistent with the patient's values.

If consent is obtained, the treatment may be withdrawn or withheld in compliance with the applicable procedures of the institution.

### 3. Procedures in cases of lack of consent regarding nonbeneficial treatment

Where there is disagreement on the course of the patient's treatment between the physician and the patient and/or the patient's surrogates, a consultation with another appropriate physician shall be offered. The patient or surrogate shall be consulted regarding the choice of a physician for this second opinion.

- A. If, after reviewing the patient's case and speaking with the patient and/or surrogates, the second physician disagrees with the primary physician, the patient and/or surrogate shall be informed of this difference in opinion and, wherever appropriate and possible, offered transfer to another physician's care and/or to another institution.
- B. If, after reviewing the patient's case and speaking with the patient and/or surrogates, the second physician agrees with the primary physician that nonbeneficial treatment should be withheld or withdrawn, the patient and/or surrogates shall be informed of this second opinion. If the patient and/or surrogate now agrees with the two physicians, the intervention in question will be withdrawn or withheld in accordance with the institution's accepted policies and procedures.

Where disagreement persists between the primary physician and the patient and/or surrogate, the following procedures shall be followed.



1. The patient will be offered consultation with additional institutional or other resources as appropriate, (such as the ethics consultation service or consultant).
2. If disagreement persists, the physician shall present the case for review by an institutional ethics committee or other body for a recommendation regarding the patient's treatment. The review committee membership should include not only relevant institutional expertise, but external community representatives without financial interest in the institution or individual case.
3. The patient and/or surrogate shall be informed (in sufficient time) of the meeting and invited to attend to present the patient's perspective. Anyone, including members of the caregiving team, who has a direct stake in the patient's care should be considered potential participants.
4. The review committee shall offer a recommendation on the case following the meeting. The recommendation shall reflect a consensus opinion of the committee, with no major disagreement, if nonbeneficial treatment is to be withheld or withdrawn (A specific minimum majority vote may be established as a criteria in such cases, such as requiring that 75% of voting members support the determination of nonbeneficial treatment). The committee's opinion shall be considered as an advisory and nonbinding recommendation for use by the primary physician and others involved in decision making in the case. The recommendation shall be accurately recorded in the committee minutes.
5. If the review committee agrees with the physician's determination of nonbeneficial treatment, the patient and/or surrogate shall be promptly informed of this decision. Surrogates shall be informed of all options available other than continuing treatment, including legal procedures (such as court orders compelling continued treatment) and transfer. If transfer to another institution is desired by the patient and/or surrogate, such transfer will be facilitated as possible. If transfer is not possible, a plan for withholding or withdrawal of nonbeneficial treatment may ethically be made, emphasizing the provision of comfort care and preservation of patient dignity.
6. If the review committee does not concur with the physician's recommendation, that physician should give serious consideration to the recommendation that treatment shall not be withheld or withdrawn or otherwise limited without patient or surrogate consent. Arrangements for transfer to another physician's care will be made if requested by either the physician or patient and/or surrogate. The current physician shall make a good faith effort to find

## CASE 2

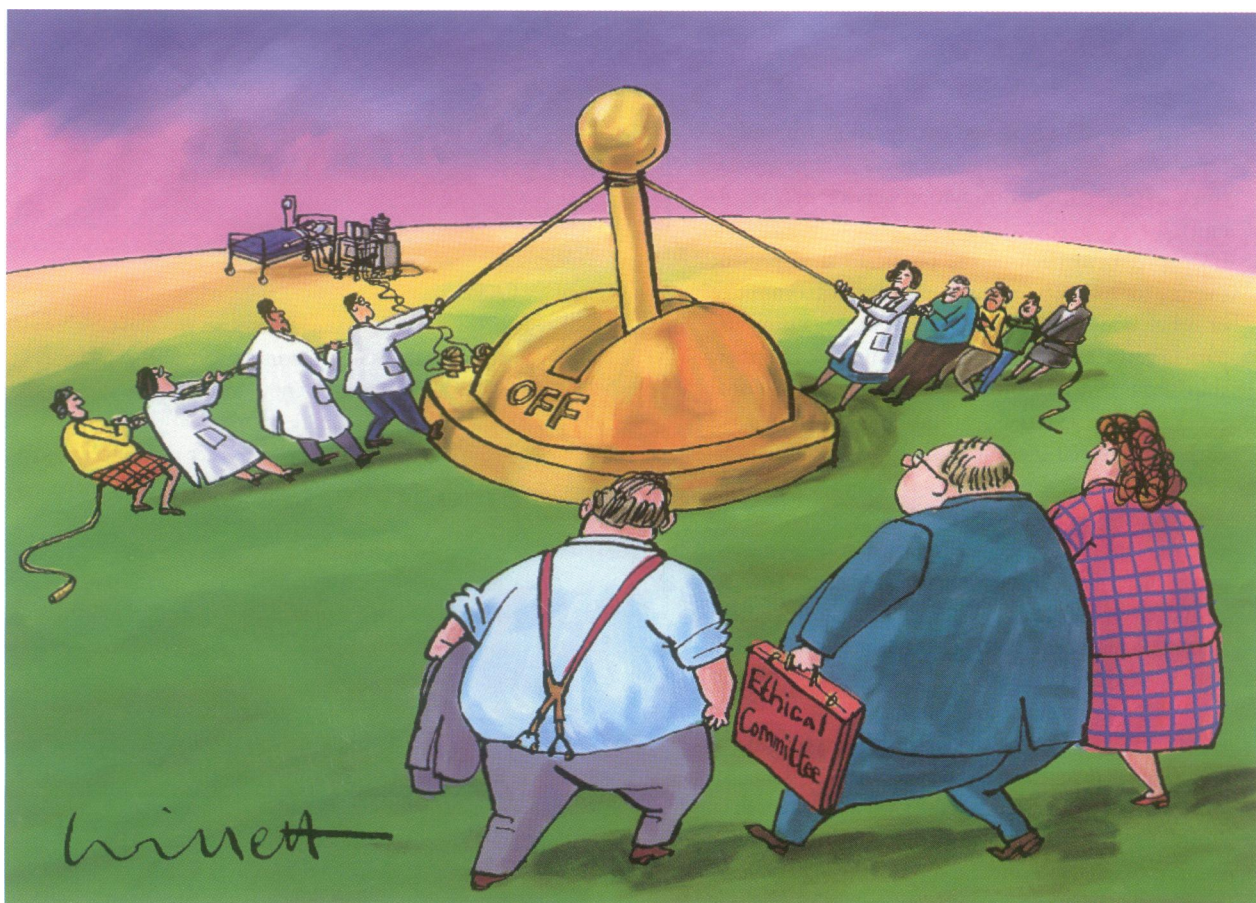
A 70-year-old African American woman is severely obtunded with multiple diseases, including heart disease, stroke, diabetes, peripheral vascular insufficiency and chronic obstructive lung disease. She cannot participate in medical decisions and is deteriorating despite maximal treatments. Her daughters, nieces, and sister, all claiming they know the patient best, disagree vehemently about how aggressively she would want to be treated. The patient has designated no surrogate decision-maker and has expressed contradictory wishes in the past. Decisions must be made about whether to perform a tracheostomy to maintain her life-sustaining ventilation, how aggressively to treat life-threatening infections, including whether to amputate her compromised extremities, and whether or not to attempt CPR in the event of a cardiac arrest.

In this case, the patient's physician felt that she should order no code-comfort care only. Some family members disagreed, so the physician requested a second opinion, which confirmed her prognosis and treatment plan. Disagreement among the family persisted. The family was invited to bring in their own consultant, but they could not agree on any. The physician requested an ethics consultation. During this meeting, which included family members and the patient's care team, the patient's condition and prognosis were reviewed in detail, and efforts were made to have the family agree on a patient surrogate. This meeting failed to achieve consensus among the family.

Further dispute resolution was attempted in a meeting involving the patient's physician and nurses, family members, and the full ethics committee. This also failed and while the committee could not agree who best represented the patient's wishes it agreed that changing the patient's treatment emphasis from aggressive life-support to comfort care was motivated by the patient's best interests and therefore was ethically defensible. The family was presented with these results of the ethics committee's deliberation, and offered counseling during a 72-hour grace period before no-code status was ordered, seeking transfer to another institution, or a court order to compel treatment. During this time, efforts were made to provide counseling, and the family was assured that the full code status would remain in place.

When transfer was not possible, the family debated what to do even as the no code order was written. The care team agreed to follow the patient for at least one more week to accommodate the family's grieving before removing the ventilator. During that time the patient developed overwhelming sepsis, which was not aggressively treated, and she died. Although one family member threatened legal action, he did not follow through on this threat.





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another appropriate physician to undertake the patient's care. Until that is accomplished, the current physician is ethically and legally responsible for the care of the patient.

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**Note:** This document represents suggested guidelines for potential policy to be used as appropriate by individuals or organizations. The Bay Area Network of Ethics committees provide a forum for open, independent discussion of ethical issues in healthcare. Opinions and guidelines proffered via BANEK are not necessarily representative of or endorsed by any organization participating in BANEK activities, and are nonbinding. Comments on BANEK policies are welcomed.

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